## IOWA BOARD OF PSYCHOLOGY

IOWA DEPARTMENT OF PUBLIC HEALTH LUCAS STATE OFFICE BLDG, 5<sup>TH</sup> FLOOR DES MOINES, IOWA 50319-0075

## SUPERVISION REPORT

A. Descrip	tion of Supervision							
1.	Duration of supervision (must be one year or a minimum of 1500 hours):							
Ве	ginning date: ending date: (mm/dd/yyyy) (mm/dd/yyyy)							
2.	Total hours of supervised professional experience accrued by the applicant:							
3.	Frequency of face-to-face, individual supervision (hours per week and total hours):							
4.	4. Mode of supervision: (Please specify the type of supervisory modalities which were employed and the proportion of total supervisory time devoted to each. For example, modes of supervision might include talking with the applicant, directly observing the applicant's counseling, therapy assessment, teaching, research or consultative work, reviewing the applicant's reports and/or notes, viewing and/or listening to tapes of the applicant's professional work, conducting co-counseling, co-teaching or joint research or consultative endeavors with the applicant.)							
5.	Goals/objectives of supervision:							
B. Evaluat	ion of Applicant							
1.	Level of professionalism:							
	a. Overall level of professionalism exhibited by applicant to perform adequately for independent practice:							

to convey knowledge and skill, affect, involvement, and identification with the profession of

psychology.)

(Applicant should be evaluated in terms of self-awareness, personal demeanor, command of and ability

## b. Comments:2. Areas of proficiency and limitations:

Low						
1	2	3	4			
b. (	Client population the applicant appears capab	ole of a	dequately serving:			
	☐ Infants & Toddlers		Elderly			
	□ Children		Business or Industrial Organizations			
1	☐ Adolescents		Other (specify)			
	□ Adults					
c. E	Evaluation and diagnostic techniques utilized at the time you supervised this applicant:					
	☐ Cognitive/Intellectual Assessment		Personality Assessment			
	☐ Perceptual/Motor		Objective			
	☐ Neuropsychological Assessment		Projective			
	□ Social Ecological		Behavioral/Observational			
	□ Educational		Interview			
	<ul><li>□ Organizational Climate</li><li>□ Other</li></ul>	Ш	Interests & Attitude			
d. ]	Intervention techniques utilized at the time you supervised this applicant:					
	☐ Play therapy		Sex Therapy			
	☐ Parent Consultation		Biofeedback			
	☐ Family Therapy		Behavior Therapy			
	☐ Group Therapy		Vocational & Career counseling			
	☐ Individual Therapy		Marital Therapy			
	☐ Special Education Program		Hypnotherapy			
	☐ Short Term Counseling		Organizational Consulting			
	□ Consultation with other professionals		Other special skills and techniques pecify)			
hics an	d conduct					
a. (	Quality of applicant's use of knowledge					
Low				ŀ		
1	2	3	4			
If rat	ed 1 or 2, explain:					
b. ]	Dogs the applicant appear aware of arrest of	mofos-	ional strongths and west-nesses as 4 :: 11	in~		
	Does the applicant appear aware of afeas of t	JOJESS	ional strengths and weaknesses and will	mg '		

2 Revised 10/11/2012

	c.			ain the appropriate sup needed:   Yes   No	pervision/consultation/education to
4.	Recomn	mendations:			
		you recommend this a ist and explain any re		re? □ Yes □ No	
If y	ou have a	any additional inform	ation that would am	plify or clarify the app	olicant's competencies, please state:
Stat	te(s) in w	hich you are currently	y licensed or certifie	ed to practice psycholo	gy:
Lic	ense/Cert	tification Number(s):			_
Effe	ective dat	tes:	to		
		month/year		month/year	
		ed in The National Rece Provider in any sta		vice Providers in Psyc	hology or certified as a
If y	es, please	e specify:			_
	re you lic Yes □ N		practice psychology	for the duration of yo	ur supervision of the applicant?
If y	es, please	e indicate State:	Name	of Licensing Organiza	tion:
Ori	ginal Issu	ue Date of License or	Certificate:		
Hig	hest degi	ree/program:			
Prii	nt name a	and address:			
					<del></del>
Sig	nature:			MU	ST BE NOTARIZED
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